# REPORT OF THE SYMPOSIUM OF FUNDING ORGANISATIONS SUPPORTING PROGRAMMES FOR DISABLED PEOPLE

26 MARCH 1990
BANGALORE

DISABILITY DIVISION

**ActionAid**

P.O. BOX 2527, 10/1 BRIDE STREET, LANGFORD ROAD, BANGALORE 560 025
TEL 212821 TELEX 0845-2142 FAX 0812-212843 CABLE ACTIONAID

REGD. H.O. HAMLYN HOUSE, ARCHWAY, LONDON N19 5PG

# REPORT OF THE SYMPOSIUM OF FUNDING ORGANISATIONS SUPPORTING PROGRAMMES FOR DISABLED PEOPLE

DISABILITY DIVISION

ACTIONAID
1990

## CONTENTS

# FOREWORD

The evolution of organised health care in most countries has its origin in curative medicine, leading to preventive medicine and then on to rehabilitation medicine. Many of the developing countries are in various stages of this evolution. India is one of the signatories to the Alma Ata Declaration of 1978, and is committed to including rehabilitation services as a part of Health for All by 2000 AD. Rehabilitation received a further fillip with the declaration of 1981 as the International Year of Disabled People and 1983-1992 as the International Decade of Disabled Persons. In many developing countries including India, rehabilitation policies and priorities have been slowly taking shape in the last few years.

According to the World Health Organisation (WHO), about 10 percent of the world's population is disabled in some way. In India, the National Sample Survey of 1981 indicated that about 1.8 percent of the country's population at that time had locomotor, visual and communication disabilities – the three disabilities that were included in the survey. Statistics from other sources show that mental retardation is prevalent in about 2 percent of the country's population. Overall, it can be said that at least 3.8 percent of the population in the country is disabled in some way, which amounts to a significantly large number of people to be taken care of.

In any country, resources to cover a large population of disabled people would be limited, as rehabilitation programmes are cost-intensive. This is more so in the case of developing countries like India. Sources of financial support for rehabilitation programmes may be internal or external. In India the Government and other non-governmental funding sources within the country provide the major internal funding support for rehabilitation programmes. Studies sponsored by the Ministry of Welfare, Government of India in certain states, as quoted by Narasimhan and Mukherjee (1986), show that the financial contribution made by voluntary agencies for the programmes they run is hardly to the tune of 10 percent of their total costs. External support denotes overseas donor organisations.

During the 1980-85 plan period, the Central Welfare Ministry's planned and non-planned expenditure for disability welfare was about Rs. 11 crores per year. Assuming that there were about 20 million disabled people in the country at that time, this amount would have averaged at about Rs. 5.50 per disabled person. Even if the Government spending on rehabilitation were to increase, along with the contributions from voluntary organisations themselves, the gap between needs and resources in cost-intensive rehabilitation programmes would still be wide and need to be addressed through other means. Considering this, along with the magnitude of the problem of disability, it is apparent that the answer lies in optimal utilisation of available resources.

For the purpose of optimal resource utilisation, the areas requiring greater attention are professional management of rehabilitation programmes, establishment of appropriate service models and trained manpower to meet the rehabilitation needs of the country, ongoing research and repeated evaluations of programmes and continuous dissemination of available data in the field of rehabilitation.

Since all these areas are important, require stringent maintenance of quality at all levels and may be costly, it may not be possible for a single organisation to develop all of them. The need, therefore, is for pooling of resources, developing strategies for co-ordination and collaboration and avoiding duplication of efforts. During the Tokyo International Congress of Rehabilitation International in 1988, the need for co-ordination among donor agencies in developing countries was one of the issues that was well brought out.

ActionAid is a UK based development organisation, supporting integrated rural development programmes in developing countries in Asia, Africa and Latin America. ActionAid has been wroking in India since 1973. In 1988, ActionAid-India confirmed the policy of earmarking part of the annual outlay for disability initiatives, which led to the formation of a separate division to deal with projects for disabled people. The disability and rehabilitation programmes supported by ActionAid are long-term ones, ranging from institution based rehabilitation programmes to community based ones.

ActionAid is now moving towards active participation in, and contribution to, the National effort in rehabilitation programmes. The time is therefore appropriate to initiate networking and co-ordination of organisations involved in supporting disability initiatives.

The objectives of the symposium were : to initiate a common forum for funding organisations involved in rehabilitation programmes to meet periodically, to share information on each other's activities, to develop possible collaborative ventures in rehabilitation in order to avoid duplication of efforts, and to widen the scope of funding resources in the country.

An attempt was made to enlist the participation of as many donor agencies involved in rehabilitation as possible. The final list of participant organisations included the Government (Central and State), UNICEF, ADD-India, Royal Commonwealth Society for the Blind. Christoffel Blinden Mission, CARITAS-India, German Leprosy Relief Association, ActionAid and Brooke Bond (India) Private Limited.

Though the representation was small, some of the participant organisations like UNICEF are significant contributors to disability initiatives in the country. The notable achievement of the symposium was that it initiated a co-ordinated effort between different donor organisations in the field of rehabilitation, firstly, in the form of a consensus for a common forum to meet every year and secondly, in the agreement on the need for collaboration in service, research and dissemination of information.

The participation in this first meeting was limited to a small number of donor organisations, some of which have large amounts of financial resources at their disposal. It would be desirable to enlarge the scope of such meetings to include many more organisations, including those with limited resources and those for whom disability may not be a priority. When the quantum of funding is small, the impact may be minimal. This can be overcome through collaboration and co-ordination between organisations in terms of management, technical and funding resources, to achieve greater impact.

What is foreseen for the future are regular meetings and collaboration between different donor organisations – Government, external funding organisations, non-Governmental and other internal funding sources. The end goal of evolving such a common forum should be to hasten the development of mutually agreed upon collaborative programmes in rehabilitation, with optimal resource utilisation.

26 March 1990.

**Dr. Maya Thomas**
Disability Division
ActionAid-India
P.B. 2527
Bangalore-560 025

# SYMPOSIUM OF FUNDING ORGANISATIONS SUPPORTING PROGRAMMES FOR DISABLED PEOPLE

DATE : 26 MARCH 1990
VENUE : MANPOWER DEVELOPMENT CENTRE, UNITY BUILDINGS, BANGALORE-27

## AGENDA

| | |
|---|---|
| 08:45 a.m. – 09:15 a.m. | – WELCOME TO DELEGATES AND INTRODUCTIONS |
| 09:15 a.m. – 10:45 a.m.<br>Chairperson:<br>Dr. R.S. Murthy, NIMHANS | – REVIEW OF ACTIVITIES:<br>1. Govt. of Karnataka<br>2. UNICEF<br>3. ActionAid |
| 10:45 a.m. – 11:15 a.m. | – COFFEE BREAK |
| 11:15 a.m. – 12.45 p.m.<br>Chairperson:<br>Ms. Mary Roodkowsky, UNICEF | – REVIEW OF ACTIVITIES CONTINUED:<br>4. Christoffel Blinden Mission<br>5. ADD-INDIA<br>6. Royal Commonwealth Society for the Blind<br>7. CARITAS-India |
| 12:45 p.m. – 01:45 p.m. | – LUNCH BREAK |
| 01:45 p.m. – 02:45 p.m.<br>Chairperson:<br>Dr. G.G. Prabhu, NIMHANS | – REVIEW OF ACTIVITIES CONTINUED:<br>8. German Leprosy Relief Association<br>9. Brooke Bond India<br>10. Raba Contel |
| 02:45 p.m. – 03:00 p.m. | – TEA BREAK |
| 03:00 p.m. – 04:00 p.m.<br>Chairperson:<br>Dr. G.G. Prabhu, NIMHANS | – DISCUSSIONS |
| 04:00 p.m. – 05:30 p.m.<br>Chairperson:<br>Dr. C.M. Francis, St. Martha's Hospital | – FUTURE PLANS OF ACTION |
| 05:30 p.m | – CONCLUSION |

# LIST OF PARTICIPANTS

1. Mr. V. Krishnamurthy

2. Mr. B. Venkatesh
   **Action on Disability and Development (ADD) India.**
   1287, 6th Cross,
   I Stage, II Phase,
   Chandra Layout,
   Bangalore-560 040.

3. Mr. G.R. Srinivasan
   **German Leprosy Relief Association Rehabilitation Fund**
   No. 10, Mettukuppam Road,
   Maduravoil,
   Madras-602 102.

4. Mr. Baburao Mudbi
   **Government of Karnataka Directorate of Disabled Welfare**
   Ground Floor, Podium Block,
   Vishweshwaraiah Tower,
   Dr. Ambedkar Road,
   Bangalore-560 001.

5. Mr. B.D. Thanawala
   **Royal Commonwealth Society for the Blind**
   (Sight Savers)
   B1/B3 Matru Ashish,
   L. Jagmohandas Marg,
   Bombay-400 036.

6. Mr. P. Christuraj
   **CARITAS – India**
   Archbishop's House,
   18, Millers Road,
   Bangalore-560 046.

7. Ms. Mary Roodkowsky
   **UNICEF**
   Nutrition Section,
   73, Lodi Estate,
   New Delhi-110 003.

8. Dr. Julius Karunakaran
   **Christoffel Blinden Mission**
   Y-82, Fourth Street,
   Annanagar,
   Madras-600 040.

9. Dr. Maya Thomas

10. Mr. Joseph Panackel
    **ActionAid (India)**
    Disability Division
    10/1, Bride Street,
    Langford Road,
    Bangalore-560 025.

**SPECIAL INVITEES**

11. Dr. C.M. Francis
    Director,
    **St. Martha's Hospital,**
    Nrupathunga Road,
    Bangalore-560 009.
    *Member-Advisory Panel on Disability, ActionAid*

12. Dr. R.S. Murthy,
    Professor and Head,
    Department of Psychiatry,
    **NIMHANS,**
    Bangalore-560 029.
    *Member-Advisory Panel on Disability, ActionAid*

13. Dr. G.G. Prabhu,
    Professor and Head,
    Department of Clinical Psychology,
    **NIMHANS,**
    Bangalore-560 029.
    *Member-Advisory Panel on Disability, ActionAid*

14. Mr. M.S.S. Varadan

15. Mr. R.R. Mohan,
    **Om Consultants (India) Pvt Ltd,**
    "Kalpataru",
    84, 9th Cross, 6th Main,
    Malleswaram,
    Bangalore-560 003.

16. Mr. Ajay Varma

17. Ms. Mini Govil,
    **Raba Contel (India) Ltd.,**
    6th Floor, Qutab Hotel,
    Sri Aurobindo Marg,
    New Delhi.

18. Mr. K. Gopinathan,
    **Community Health Cell,**
    47/1, St. Mark's Road,
    1st Floor,
    Bangalore-560 001.

# Welfare Services for the Handicapped – Government of India

*The Government of India was to have been represented by a senior official from the Ministry of Welfare, New Delhi. Due to pressing commitments, the participant was unable to be present at the symposium. The following is a publication which details the activities of the Ministry of Welfare, Government of India.*

There is a growing awareness both in the Government and society about the need to reach out to the disabled people to enable them to become self-sufficient and independent. Towards this end both Government and voluntary agencies have undertaken measures for providing para-medical services, special education, support and care facilities, early intervention and family therapy, the development of techniques and new technology for artificial aids and appliances to increase the independence and quality of life of disabled persons. Today there is a growing recognition that disabled persons must enjoy and have access to the same rights and opportunities that are taken for granted for the rest of the society. Towards achieving this goal, integration is of a paramount importance. It is not just enough to provide the disabled with physical and occupational therapy, special education or vocational training. The attitudes which create separation in society must give way to a new determination to strive for and achieve integration. For this it is necessary not just to rehabilitate the disabled but also to change the attitudes of the able bodied for integration in its fullest sense depends on each and every one of us.

The history of rehabilitative services in the Government sector is fairly recent. Historically the service delivery for the disabled was concentrated in the voluntary sector. Social welfare services, especially in the fields of medicine and rehabilitation were undertaken by missionary activists as a part of their general programmes of social and economic development. As a result, a large number of societies in the non-governmental sectors were established, depending mainly on public support and donations, who would look after the sick and infirm, the destitutes and the disabled. In recent years these services have gained importance and the Government has stepped in to make these services standardised, professional and on par with such services offered all over the world. The Government has since independence been focussing attention on the prevention of disabilities, provision of physical restorative services, development of personnel and resource persons through the training of professionals, development of services through research and field trials and social and economic measures such as executive orders and enactments to ensure just distribution of the fruits of development to the handicapped population.

There are over 1000 voluntary organisations in India working in the field of welfare of the handicapped. Out of these about 350 receive grants from the Government of India. The State Governments have their own schemes of financial assistance to NGOs.

**Grant-in-Aid**

The Ministry of Welfare has two major schemes for giving Grant-In-Aid to voluntary organisations. These are the scheme of assistance under which grants are given for recurring and non recurring expenditure upto 90 per cent of the budget of the grantee organisation. The grantee organisation is expected to meet the balance of 10 per cent by raising its own resources. Assistance is given under this scheme for developing services for the disabled for the prevention of disability, special education and vocational training, training of resource persons, provision of therapeutic services such as physical therapy and occupational therapy, placement services etc. Grants are also given for the construction of buildings and purchase of equipment. The second major scheme under which grants are given to voluntary organisations is the scheme of assistance to disabled persons for purchase and fitting of artificial aids and appliances. Under this scheme needy physically handicapped persons are assisted in procuring durable and sophisticated standard aids and appliances to promote their physical, social and psychological rehabilitation. Aids and appliances are given to all categories of disabled persons. These include orthotic and prosthetic aids for the orthopaedically handicapped, hearing aids for the hearing handicapped and educational kits such as Braille slates and Braille measuring devices, Braille writers and taperecorders for the visually handicapped and corner seats and prone boards for the spastics. Tri-cycles, wheel chairs and orthopaedic shoes are also provided in deserving cases to physically handicapped persons. The aids and appliances are given free of cost to those persons whose income is upto Rs. 1200/- per month and at 50% of the cost to those whose income is between Rs. 1201 to Rs. 2500. Aids and appliances costing between Rs. 25 to Rs. 3600 are covered under this scheme.

In 1988-89 nearly Rs. 960 lakhs were given as Grant-In-Aid to voluntary organisations by the Government of India under these two schemes.

There are four National Institutes in each major area of disability under the Ministry of Welfare. They are: the National Institute for the Orthopaedically Handicapped at Calcutta, the National Institute for the Visually Handicapped at Dehra Dun, the National Institute for the Mentally Handicapped at Secunderabad, and the Ali Yavar Jung National Institute for the Hearing Handicapped at Bombay. These Institutes have been designated as apex organisations for training of professionals, production of

education materials and other aids for the handicapped, conducting research in rehabilitation and development of suitable model services for the handicapped. These Institutes work in coordination with each other and other training centres in the country, leading voluntary organisations, State governments as well as International agencies to enforce standards in various institutions of the handicapped and standardisation of training programmes. An apex body known as the Rehabilitation Council has also been set up under the Ministry of Welfare. The Rehabilitation Council prescribes syllabii for the various training programmes, recognises the training institutions and maintains rehabilitation registers.

**District Rehabilitation Centre Scheme**

To further ensure that the resource persons of the voluntary organisations get proper training the National Institutes organise refresher courses for the in-service personnel of the voluntary organisations in batches.

A number of voluntary organisations such as the Spastics Society of India, Spastics Society of Northern India and the Spastics Society of Eastern India are conducting courses for resource persons for the special education and training of persons with cerebral palsy. These organisations are voluntary organisations in the non-governmental sector. They are getting grants from the Ministry of Welfare and through other agencies on the recommendations of the Ministry of Welfare to conduct these courses. A number of other organisations such as the School and Training College for the Deaf, Lucknow, Abhinav Bharati Manovikas Kendra, Calcutta and Society for the Remedial Educational Assessment and Counselling of the Handicapped, Calcutta are also conducting the training of resource persons in their respective fields of disability.

It has been estimated that nearly 80 per cent of the disabled population in India live in the rural areas. However, the services in the Government as well as non-governmental sectors are largely concentrated in urban areas. To rectify this anomaly the Ministry of Welfare started the District Rehabilitation Centre Scheme in 1983. The DRCs were strated on a pilot basis in 10 districts in the country. The scheme envisages comprehensive identification of disabled persons in the area of operation, following which restorative, medical, educational, vocational and placement services are arranged for the disabled persons. The scheme envisages close integration with the Health and Educational infrastructure already available at the field level and close interaction of the community in the rehabilitation process. The DRCs, where functional, are acting as important catalysts to non-governmental organisations. It is the policy of the Ministry of Welfare that the DRCs should concentrate on assessment, clinical and therapeutic services and encourage non-governmental organisations to provide community awareness, parental counselling and vocational training services.

The Government of India, keeping in view the magnitude and quality of the requirements of disabled persons, has set up the Artificial Limbs Manufacturing Corporation (ALIMCO) in the public sector in Kanpur to produce high quality aids and appliances for handicapped persons.

The ultimate aim of every rehabilitated handicapped person is gainful employment. A handicapped person who is employed not only becomes a productive member of society but also achieves confidence and self respect in the process. For preparing, handicapped persons to take up employment and self-employment, training in various vocational activities is provided. Training facilities are available both in the Government and voluntary sectors. About 100 training institutions, out of which 50 are in the Government sector, exist for providing training in a variety of vocational activities to the handicapped persons. Loans are also available from nationalised banks at concessional rates of interest for the handicapped persons to set up self-employment ventures. The Government has reserved 3 per cent of vacancies in group 'C' and 'D' posts in the Government and public sector undertakings for the disabled persons. A 10 year relaxation in age has also been offered to enable them to take advantage of the reservation policy. Many State governments have their own programmes of reservation in jobs besides other facilities. The Central Government gives special concessions to handicapped persons which include concessions for travel by bus, train and air, conveyance allowances to disabled Government/public sector employees, petrol subsidy to handicapped persons owning their own vehicles. The Ministry of Petroleum and Natural Gas has made a certain percentage of reservation for allotment of petrol pumps/ gas agencies/kerosene oil depots to handicapped persons. These people are also given contracts for manning public telephone booths. Priority is given to disabled persons in the allotment of government houses and a certain percentage of flats and plots of various housing boards is also earmarked for handicapped persons.

The Ministry of Welfare also has a scheme of scholarships from class IX upwards for handicapped students. Scholarships and stipends are given for studies upto the master's level including specialised study in the field of medicine, engineering, law and any kind of vocational training. Stipends are also given for undertaking music courses. In 1988-89, a sum of over Rs. 315.25 lakhs was distributed under the scholarship scheme.

A draft legislation for the disabled pertaining primarily to employment and access facilities in building and public places, has also been prepared. It is expected that this legislation will be passed very shortly.

Since awareness and access to information play a major role in rehabilitation, the Ministry of Welfare, Government of India has set up a National Information Centre on Disability and Rehabilitation (NICDR). This Centre will collect, document and disseminate comprehensive information on facilities and services available to the disabled people and maintain a data bank of professionals pertaining to disability rehabilitation. The data bank will be

fully computerised and provide information to anybody interested in getting this information. A bi-annual journal called the Indian Journal of Disability and Rehabilitation is also brought out by the Ministry of Welfare.

The S&T Project in the Mission Mode on Application of Technology for the Welfare and Rehabilitation of the Handicapped has been set up in the Ministry of Welfare. The Project will examine the scope of development of artificial aids and appliances, hardware and software utilising the new and emerging areas of technology. The Project aims at the development of about 40 aids and appliances during the next 5 years. The Project will adopt an end-to-end approach beginning with the identification of the disabled, their problems, development of suitable-aids and appliances to improve their daily living, employability, recreation and integration in society. The S&T Project has already funded twelve initial projects.

It would be relevant to mention that the Government with a view to providing an impetus to employers, employees, placement officers, social workers and scientists in the field of the welfare of the handicapped has introduced a scheme of National Awards. These awards are given away each year by the President of India on World Disabled Day. The World Disabled Day is observed on the third Sunday of March which traditionally is said to herald the advent of spring. Spring is the season of hope and rebirth, concepts which are symbolic and very relevant to the rehabilitation of the disabled □

**Shipra Mandal Sinha**
Director (HW) and Project Director,
DRC, Ministry of Welfare, New Delhi.

# Directorate of Disabled Welfare – Government of Karnataka

**I. Plan Programmes**

1. *Directorate of Disabled Welfare, Bangalore*

   The Directorate has been newly created and started functioning from 1.8.1988. For 1988-89 a budget of Rs. 25 lakhs had been allotted and an expenditure of Rs. 3,70,000 was incurred. For the current year Rs. 17 lakhs has been allotted, with an expenditure of Rs. 5,19,146 upto February 1989. The Directorate has given a proposal for creating additional posts at the Head Office, District and Taluk level Offices. In the same proposal it was proposed to create some very important posts and Account Cell at the Head Office for which the Department has a budget of Rs. 10 lakhs during 1989-90.

2. *Development of school for Deaf and Blind*

   The main objective of the scheme is to strengthen the existing Government schools and to create new posts. Rs. 3 lakhs has been allotted for this purpose for the year 1989-90. An expenditure of Rs. 1,66,707 has been incurred towards the development activities upto January 1990. This academic year 8th Standard has been started in Deaf School, Gulbarga.

   The Department has also given a proposal for the establishment of a Regional Centre of National Institute of Hearing Handicapped in Karnataka, for the benefit of the deaf in the State.

3. *Education Training under Rehabilitation programme for Physically handicapped and Mentally handicapped*

   The main objective of the scheme is to provide assistance to run the Industrial Training Centre for blind in Mysore in collaboration with National Association for Blind, Bangalore and to strengthen the existing Grant-in-Aid Institutions. This training Institute has been recently started. Last year Rs. 6 lakhs were sanctioned for two sheds, furnitures and other items. For the current year Rs. 4 lakhs has been allotted, out of which Rs. 3,98,208 has been released.

4. *Hostel for working disabled employees and Trainees (Men and Women), Bangalore*

   This is to provide hostel facilities for the disabled who are employed or undergoing training. There are 47 boarders at present. Rs. 2,20,690 expenditure is incurred, out of a Rs. 3 lakhs budget allotted during 1988-89. Rs. 2,46,680 was spent out of the Rs. 3 lakhs budget upto January 1990.

5. *Braille Printing Press, Mysore*

   The Braille Printing Press, Mysore, has been functioning from 1984, to print reading materials for blind students and to supply to Government and Non-Government Institutions. During 1988-89 Rs. 3 lakhs was allotted and an expenditure of Rs. 3,32,953 was incurred. Rs. 1,32,232 has been spent out of Rs. 3 lakhs budget allotted upto January 1989.

   A proposal for publishing of a quarterly journal for the benefit of Blind has already been sent to the Government for approval.

6. *Seed Money Scheme*

   The Scheme is implemented through Karnataka State Financial Corporation since 1981. The objective of the scheme is economic rehabilitation and recognition of the potentials of the eligible enterpreneurs among disabled persons. For loans upto Rs. 25,000, 25 per cent is given by the Department as subsidy.

   During the year 1989-90 Rs. 4 lakhs budget has been allotted. Karnataka State Financial Corporation has provided loans to 54 beneficiaries and a total amount of 14.54 lakhs has been incurred upto December 1989.

7. *Welfare of the Handicapped (Building)*

   The main object of this scheme is to construct new buildings for various Government institutions. During the year 1989-90 Rs. 10 lakhs has been provided, out of which Rs. 1 lakh for Blind School, Devanagere, Rs. 2 lakhs for Deaf School, Gulbarga, Rs. 5,62,000 for Mentally Retarded Women and Rs. 1,38,000 as administrative approval for Deaf School, Gulbarga, has been accorded.

**II. Non-Plan Programmes**

1. Under this department 4 deaf and 4 blind schools are running in different places. In these schools there are 304 blind and 365 deaf children for whom free boarding and lodging facilities are provided. During 88-89 Rs. 49,07,516 was spent out of the Rs. 54,05,000 budget allotted. During this year Rs. 45,21,344 was spent upto January 1990.

2. *School/Training Centres run by Voluntary Organisations*

   In addition to Government Schools 83 voluntary institutions are running various welfare services for the disabled in Karnataka.

   i) ***Permission for starting P.H. Schools***

   During the year 1989-90, 50 applications for starting new Schools all over Karnataka were received in the Directorate.

   The matter of according permission was discussed at length at the Government level. The Government in their letter dated 26.10.1989 have given clear instructions that no new schools for orthopaedically handicapped would be allowed.

ii) ***Recognition to the schools run by Voluntary Organisation***

There are in all 83 schools, training centres/ rehabilitation centres run by the NGOs in the State.

Out of these, 3 schools are given recognition and 36 are given permission to run the schools. There are a number of unauthorised schools run without permission.

A press statement has been issued, cautioning the general public about the unauthorised schools.

Voluntary organisations are given financial assistance from State and Central Governments. The State financial assistance of Rs. 22,06,150 has been spent on 20 Voluntary organisations out of Rs. 18,10,000 budget allotted. Rs. 34,78,102 is proposed for 20 voluntary organisations during 88-89 which are taking grants from Government of India. For 88-89, State financial assistance of Rs. 5,02,543.30 State Financial has been given to 6 voluntary organisations upto November, 1989 and Rs. 32,35,499 recommended to 16 voluntary organisations which are taking grants from Government of India.

iii) ***Old age Homes***

There are 4 Old age Homes run by voluntary organisations in various places for old, infirm and disabled persons. Financial assistance of Rs. 87,911 has been given during 88-89. The proposal for 89-90 has been received from the organisations and the release of grants is under process.

iv) ***Monthly Financial Assistance to the Disabled Poor***

Disabled persons whose family income is less than Rs. 6,000 per annum are entitled to get maintenance allowance of Rs. 50 per month. The Tahsildar of the concerned Taluk sanctions the maintenance allowance. During 88-89, Rs. 13 crores was allotted for this purpose and an expenditure of Rs. 12.18 crores was incurred. For the year 1989-90 an amount of Rs. 14 crores has been provided for the purpose. Rs. 9,97,00,000 has been spent on 2,13,000 beneficiaries upto December 1989.

v) ***Financial Assistance to Physically Handicapped Individuals: Supply of Tricycles***

During 88-89, 7 motorised tricycles and 13 hand operated tricycles have been disbursed and an amount of Rs. 54,434 has been spent for this purpose. Orders have been placed for supply of hand operated tricycles with the ALIMCO, a Government of India undertaking.

vi) ***Scholarships to Physically Handicapped***

1. *State Government Scholarship*

   Physically handicapped students who are studying from 1st to 8th Standard and whose family income is less than 10,000 per annum, are eligible for scholarships. During 88-89 Rs. 36,96,440 was disbursed to 10,557 students out of the Rs. 65 lakhs budget. For the current year Rs. 48.50 lakhs budget has been released to concerned officers to sanction scholarships.

2. *Central Government Scholarship*

   The students who are studying in 10th standard and above and whose income is less than Rs. 24,000 per annum are eligible for this scholarship. During 1989-90 Rs. 38.50 lakhs budget has been released to concerned officers to sanction scholarships.

vii) ***Social Service Complex***

The Department is running an Institution for old, infirm and disabled poor persons. There are 54 inmates who are given free food, shelter and other facilities. During 88-89 Rs. 4,37,973 was spent, out of the Rs. 6,09,000 budget. During the current year Rs. 4,27,453 has been spent out of Rs. 6,01,000 allotted upto end of January 1990.

viii) ***50 Percent Petrol Subsidy***

Disabled persons who have motorised tricycles and whose income is less than Rs. 2,500 per month, are provided with 50 per cent subsidy upto a maximum of 15 litres of petrol per month in the form of cash. During 1988-89, 29 beneficiaries have benefitted and an amount of Rs. 18,031 was spent. This is an ongoing scheme.

ix) ***Dialogue with NGOs***

Realising the need for enlisting the support of NGOs and improving upon their participation, the Directorate has initiated a dialogue with NGOs working for the disabled in the State. Already two State Level meetings have been held and major objectives for future course of action have been evolved. A very comprehensive proposal for revised Grant-in-Aid Code has already been submitted by NGOs. The response of the NGOs to this inititiative has been appreciated by UNICEF, who have come forward to share the cost of such efforts.

x) ***Preparation of a Comprehensive Policy for Disabled in Karnataka***

The Karnataka Government has taken a major step in formulating a comprehensive policy for disabled in Karnataka. The Education Department and the

Directorate of Disabled Welfare have been able to prepare a draft policy and have already conducted a workshop on this subject.

xi) ***Promoting of I E D***

The Director of Disabled Welfare is one of the members of the I E D Committee. The Government is well aware of the Scheme stipulated in the National Policy on Education by Government of India. The Department has already taken the decision to ban special schools for orthopaedically handicapped in the State.

xii) ***Approach Paper for 8th Five Year Plan***

To provide a minimum infrastructure for disability services, education and training and rehabilitation services for the disabled, specific schemes have been worked out in the approach paper for 8th Plan.

xiii) ***Participation of the Director, Disabled Welfare in Rehabilitation International World Assembly, held in Madrid, Spain during October 1989***

Sponsored by the UNICEF South India Office in Madras the Director of Disabled Welfare, Karnataka participated in the World Assembly of the Rehabilitation International on 18th and 19th October 1989, held in Madrid, Spain. The participation of the State will contribute a lot for the future programmes in community based rehabilitation and NGOs participation in the State.

xiv) ***The Community Awareness Efforts***

The Department has brought out a booklet "Hombelaku" on Welfare Programmes of the Directorate. For the first time an awareness stall was organised in the Mysore Dasara Exhibition from 30th September to 26th November, 1989.

**III. District Rehabilitation Centre at Mysore**

The District Rehabilitation Centre in Mysore is a Pilot Project sponsored by the Government of India and UNICEF. This scheme was started in the year 1983 in T. Narasipura taluk of Mysore District. The Director of Disabled Welfare is the Project Co-ordinator for District Rehabilitation Centre, Mysore.

The District Rehabilitation Centre is designed to provide comprehensive rehabilitation service to the following categories of disabled population within the geographical area of the district:

a) Speech and hearing impaired,
b) Visually impaired,
c) Mentally retarded, and
d) Those with motor handicaps.

The major objectives of the District Rehabilitation Centre, Mysore as a Pilot Project are as follows:

a. To devise suitable delivery systems to reach the entire population in the geographical area of the district.
b. To promote the most cost effective technology.
c. To restructure the present jobs so that the minimum number of specialists would be utilised for delivery of the services, and
d. To develop training programmes for the development of a new type of manpower evolved by the Centre.

In the initial stage emphasis will have to be on creation of public awareness, prevention, early detection, parent counselling and physical restoration services. This project has been started on an experimental basis.

During the year, surveys have been completed in about 179 villages and 3220 disabled persons have been identified for whom rehabilitation services are being designed. The disabled persons are also being given scholarships and aids, which are required for their rehabilitation.

The Government of India has sanctioned Rs. 10 lakhs for the construction of District Rehabilitation Centre building at Mysore during the year 1988-89 □

**Baburao Mudbi,**
Director,
Directorate of Disabled Welfare,
Goverment of Karnataka.

# UNICEF and Disability

The background paper on UNICEF programmes and activities could not be obtained before this report went to press. The following paragraph is a summary of the presentation made by the UNICEF representative at the symposium

The UNICEF emphasis in disability programmes is on prevention, early detection and rehabilitation. The disability programme budget of UNICEF has been doubled from 21 crores to 43 crores in the Eighth Plan. UNICEF works mainly through the existing Government programmes like ICDS and other services for prevention, early detection and rehabilitation. The thrust areas for funding relate to upgradation of managerial capabilities of NGOs, training of frontline personnel, programme planning, projects to ensure self-sufficiency of NGOs, preparation of case studies for dissemination of information about successful NGO experiences and pooling of communication and awareness building activities. UNICEF plans to bring out printed guidelines for funding of NGO projects in the near future □

# ActionAid – India and Disability

## Introduction

It was in the early 1950s that the member countries of the World Health Organisation (WHO), including India, began to stress the need for national health planning, as health began to be considered an important and integral part of the country's overall socio-economic development. In the initial two decades following independence, the national priorities in health were mainly in building-up basic health services and infrastructue to promote the curative aspects of health care. This was followed by the initiation of strong drives towards primary prevention with the Government of India launching major National Programmes on prevention and promotion aimed at eradication, control and mass education regarding communicable and non-communicable diseases. In the 1970s, changes in WHO policies and priorities focused attention on the need to view health care as a comprehensive system, with curative, promotive, preventive and rehabilitative components, along with the need for alternative strategies in health to reach larger sections of the population. With this was initiated the move to include rehabilitation as a natural and essential component of health care. Rehabilitation had received relatively scant attention in the earlier decades where the more pressing need facing the country was for curative and preventive interventions in health. Besides, rehabilitation, requiring institutions with specialised staff and technology, had always been viewed as cost-intensive. The area came into greater prominence with the declaration of 1981 as the International Year of Disabled Persons and the adoption of 1983-1992 as the UN Decade of Disabled Persons.

The status of rehabilitation services in India in the past few decades has been such that less than 3 per cent of disabled people needing services actually receive them. The majority of such services are located in urban areas and are thus inaccessible to rural populations. They are institution based, requiring specialised staff and technology. Most rehabilitation services have been provided by organisations working in isolation, leading to fragmentation of services. Besides, the number of trained manpower in the field of rehabilitation is grossly inadequate.

Health care in India has moved towards the era of integrating rehabilitation into the comprehensive health care system. The District Rehabilitation Centre (DRC) model of the Government is one such effort at providing rehabilitative services within the existing primary health care systems. This trend is likely to increase in the non-government sector. A related trend would be the integration of services for disabled people into development programmes supported by Government and other funding organisations, which hitherto have concentrated on schemes for alleviation of poverty such as education, women and child welfare, water and sanitation, agriculture and income generation in specified target areas.

It is important to establish good co-ordination and networking among organisations involved in rehabilitation services in Government and non-government sectors, since rehabilitation programmes are cost-intensive and future efforts are likely to be collaborative ones. With this, inequalities and duplication of coverage may be reduced and programmes appropriate for the country, in line with National priorities, may be developed.

Existing facilities for training of manpower in the field of rehabilitation are inadequate to provide for the needs of the numbers of disabled people in the country. This is an area which requires greater attention of organisations in the NGO sector in the future.

The importance of improved technology for the development of physical restorative aids and appliances to promote mobility and independence in disabled people is another area for consideration.

Public education and awareness building activities, including information about the prevention, prevalence and management of disabilities would help in changing attitudes towards disabled people and focus on their abilities and potential, which otherwise would be ignored by the able-bodied. In addition, dissemination of information of facilities, schemes and services is necessary to create awareness about and demand for such services from disabled people and their families. Organisations working for disabled people will have to address the issue of extensive documentation and dissemination of information for the target population of disabled people in the future.

## ActionAid – Background

ActionAid is a UK based development organisation, supporting programmes in countries in Asia, Africa and Latin America. ActionAid exists to help children, families and communities in the world's poorest countries to overcome poverty and secure lasting improvements in the quality of their lives.

ActionAid is committed to:

- working with communities to design, fund and manage integrated rural development programmes that respect people's cultures and values,
- providing emergency relief when circumstances demand,
- rigorously evaluating the effectiveness of the work and promoting the most promising methods and strategies.

In developed countries, ActionAid:

- raises funds to make possible programmes and activities,
- increases public understanding of the causes of poverty and commitment to the needs of the poorest,
- contributes to the public policy debate on aid and development issues.

## ActionAid – India

ActionAid has been working in India since 1973, supporting indigenous non-governmental organisations which provide scope for community development through education, health care, agricultural improvement, water development

and income generation – social and economic programmes which enhance prospects for the whole community.

The majority of funds are raised through child sponsorships. ActionAid uses sponsorship funding principally as a means to ensure support for projects and initiatives which undertake long term integrated rural development programmes and disability rehabilitation programmes in designated areas and among specific target groups.

ActionAid considers the following as its main target groups in India:

- ☐ People below the poverty line as generally recognised in India,
- ☐ Scheduled castes and tribes,
- ☐ Physically, mentally and socially disadvantaged people.

ActionAid's sponsorship income is supported and enhanced by the raising of non-sponsorship funds from ActionAid groups, individuals and private companies in the UK as well as British and European Government sources.

**Disability Division**

ActionAid – India (AA-I) had been supporting projects for disabled children for the past 10 years, considering them as small and special projects. There were 23 such projects for physically, mentally and socially disabled children, supported by AA-I, in the northern and southern States. The majority of these were schools and/or homes for the disabled children, with emphasis on education and medical rehabilitation. Most of them were urban based.

In 1988, the policy of earmarking some of AA-I's annual outlay to promote disability programmes was confirmed, which led to the formation of a separate department to deal with projects for disabled people.

**Policy Guidelines**

It was decided that projects for physically and mentally disabled people would be the priority rather than projects for the 'socially handicapped'.

In line with national priorities and policies in the area, the following areas were decided on for consideration:

a) Projects working to provide services in areas where such services are absent and where they are most needed, with family and community oriented approaches and with good linkages and referral chain.

b) Developing a cost-effective methodology of service delivery for a more comprehensive coverage of disabled people.

c) Developing technology in terms of aids and appliances to promote mobility and independence in disabled people.

d) Training of manpower in the field of rehabilitation.

e) Networking and information dissemination in the area of rehabilitation.

f) Evaluation of coverage, effectiveness and impact of rehabilitation programmes.

g) Integration of disability rehabilitation programmes into existing AA-I development programmes.

**Projects**

In the early Eighties, concern about the increasing costs and poor coverage of existing rehabilitation strategies led WHO to promote the Community Based Rehabilitation (CBR) approach as a possible cost-effective alternative to provide better coverage of disabled people in developing countries. In line with this, the projects that are selected for support by ActionAid are multi-disability community based initiatives in urban slums and rural areas. The programme interventions are in the areas of education, health and medical rehabilitation, vocational training and income generation, social rehabilitation and awareness building. Smaller projects involved in single intervention activities are also supported. We are attempting to develop projects involved in training of manpower in rehabilitation and manufacture of aids/appliances for disabled people. In connection with this, we sponsor short-term training workshops or courses.

**Library and Information**

A small library has been started with literature (books, journals, newsletters) related to disability and rehabilitation, collected from organisations in India and abroad. This would be an on-going activity. We also plan to bring out an annual newsletter with the divisional activities.

**Awareness Building Activities**

As part of the effort towards awareness building, we plan to utilise the media – print and audio visual – to focus on the importance of rehabilitation of disabled people and ActionAid's involvement in the area, using some of our existing projects as examples.

**Research and Evaluation**

It is planned to have research as an integral part of all new initiatives that are taken up, starting with establishing baselines, evolving indicators to measure progress and assessing the impact of the programmes on the target population.

**Networking**

This has been an on-going effort, with other funding organisations including the Government, non-governmental organisations, industries and other organisations involved in disability rehabilitation programmes. This Symposium is one such effort at networking which we hope would become a regular annual feature, organised by different agencies in rotation. We visualise that networking would eventually lead to mutually agreed upon rehabilitation priorities and policies for the country and to possible joint ventures in large scale rehabilitation programmes, so as to reduce duplication of efforts. Besides matters related to policies and programmes, we need to work on research in the area of rehabilitation more intensively. Perhaps we can think of collaborative multi-centric research studies, with common tools and methodology which would help in building up a database of information on the work going on in the country ☐

**Dr. Maya Thomas.**

# Christoffel Blinden Mission

CHRISTOFFEL BLINDEN MISSION e.V. (CBM), whose international headquarters is based in Bensheim/West Germany, with affiliates known as CHRISTIAN BLIND MISSION INTERNATIONAL (CBMI) in USA, Canada, Australia and Switzerland, is an interdenominational Christian mission organisation assisting national churches, international missions and other agencies overseas by providing funds, expert personnel, and professional counsel, in order to prevent and cure blindness, to educate and rehabilitate blind and physically handicapped persons, treat the sick and help the poor, irrespective of religion, race, age, or handicap.

Named in honour of its founder, Pastor Ernst Christoffel, who worked from 1908 – 1955 among blind and handicapped people in the Middle East, the ministry of CBM/CBMI has grown rapidly in the past 20 years and is now reaching out to nearly 100 countries in Asia, Africa, Latin America and Europe. One Continental Office for Africa in (Kenya), 8 Regional Offices (in Malaysia for South East Asia, in Thailand for East Asia, in India for South Asia, in Kenya for East Africa, in Togo for West Africa, in Botswana for South Africa, in the Dominican Republic for Central America and in Paraguay for South America) and two Country Offices (in Israel and Ethiopia) oversee the implementation of our activities and offer the services of professional consultations in the field of ophthalmology and optometry, education and rehabilitation, to advise, guide and counsel the projects as well as assist and evaluate project performance so as to advise and help headquarters in all its decision-making processes.

In comparison with other organisations, CBM/CBMI has refrained from directly establishing and implementing its own projects overseas. Instead, CBM/CBMI supports the efforts of churches and missions overseas to enable the national Christians to help their suffering countrymen. The support is manifold: financial aid to cover operational expenses, provision of teaching aids and medical equipment as well as drugs, medicines, and instruments; but even more important, the secondment of expert personnel (at present about 200 co-workers), who help to plan and carry out programmes for diseased and disabled, sick and suffering people.

In 1988 alone, through CBM/CBMI's partners overseas, treatment was given to over 5 million patients including a total of over 290,000 eye operations, of which nearly 138,000 were sight-restoring cataract surgeries. CBM/CBMI has recently pioneered the mass production of simple eye glasses by appropriate methods and distributes year by year nearly 300,000 spectacles. In addition, more than 645,000 school chilren were screened for eye diseases, and support was given to 663 boarding schools and training centers for the blind, deaf, and physically handicapped, with a total of more than 82,000 proteges receiving daily care.

Since it has become increasingly clear that the battle against world blindness cannot be fought with traditional methods of ophthalmology and rehabilitation alone, the prevention of blindness requires a multi-disciplinary effort involving the ophthalmologist for treatment, the optician for the provision of visual aids, the health worker to assist the family to improve personal hygiene, the vocational rehabilitation counsellor to evaluate skills and to plan placement, self-employment or training programmes, and a corps of community volunteers to co-ordinate and stimulate participation at all levels.

The funds for CBM/CBMI's worldwide services are raised entirely from individual donors numbering over 500,000 in Germany, USA, Canada, Australia, Switzerland, and Austria. The annual budget of more than 30 million dollars is allocated to assist around 1,000 permanent projects doing grass-roots level work, mostly in the poorest areas in about 90 of the neediest Third World countries.

In addition, CBM/CBMI has vigourously contributed to international efforts to help the blind and disabled by collaborating with Prevention of Blindness organizations and programmes nationally and internationally, to promote the training of national personnel in eye care at all levels, to prevent childhood blindness due to malnutrition and measles, to provide even more surgical services to operate upon curable blind people, to fight trachoma as well as onchocerciasis, and to promote the local production of eye drops and the establishment of optical workshops. In the field of education and rehabilitation of the blind and disabled new methods are promoted, such as integrated education for the blind and community-based rehabilitation programmes for the disabled □

**Dr. Julius Karunakaran**

# Action on Disability and Development (ADD) – India

## Introduction

Action on Disablity and Development (ADD) – India was established by a group of disabled people and their friends with the following aims:

To relieve poverty and sickness amongst disabled and handicapped persons throughout India,

To advance any other exclusively charitable purpose for the benefit of disabled and handicapped persons,

To assist any other person, body or organisation engaged or seeking to engage in similar activities,

To carry on any appropriate activity for raising funds for the above mentioned objects.

## Philosophy

ADD-I rightly believes that disabled people are in the best position to know their own needs and therefore should be properly consulted. The aim of consultation is to enable them to identify their needs and support them to meet those needs if they so desire. In other words, the primary aim of ADD-I is to encourage disabled people to form themselves into self help groups to work for their own development. After all self help is the best help.

In addition, unless the decision making power is with disabled people, change as envisaged by them will not take place. If leadership opportunities are not available to disabled people leadership among them will not grow.

A disabled person understands the development needs of another disabled person. This is not so much because of a shared disadvantage but more because of a common experience. Whether the individual concerned is being prevented from independent action by kindness or by discrimination it still amounts to oppression.

ADD-I helps disabled people to identify their own needs and the best ways of fulfilling them. We take time to sit under the meeting trees in the villages and really get to the roots of the problems of disabled people.

## Common Needs

The most commonly identified needs are:

better appropriate transport,
orthopaedic support,
education and training, and
the right to earn a living.

By listening to the plans made under the meeting tree we not only support practical cost effective projects but also enable disabled people to show society that there is another way.

## Policy

ADD-I is committed to work with disabled people in villages in South India to start with. The reason for this policy is that 80 per cent of the disabled population lives in villages, whereas all the facilities for education, training and employment for disabled people are concentrated in cities and in big towns as repeatedly stated by service deliverers. Hardly any such facility exists for disabled people in villages.

Therefore, ADD-I's aim is to change this situation so that disabled people in villages have access to education, skills training and employment, thus becoming contributors to the communities in which they live and ceasing to be only consumers as they are now.

## Strategy

There are atleast a few thousand voluntary agencies working in villages with other marginalised people.

The strategy is to work through these voluntary agencies to reach disabled people in villages. The reason for this strategy is not to duplicate infrastructure and to add on disability as a development issue to the agenda of existing voluntary agencies.

Disabled people, after all, live in the villages where these agencies are already working. The aim of any programme with disabled people is to integrate them into the community they live in. So work with disabled people should also be an integral part of voluntary work.

## Present Situation

Disabled people are small in number in a village and are scattered throughout the population. They have been subjected to negative social attitudes and religious prejudices. This has made them belong to a culture of dependence and silence. Therefore, like the rest of the community the voluntary agencies lack visibility to disability. Like the rest of the community, voluntary sector does not see disabled people as people with abilities.

The medical and rehabilitation models have largely contributed to this attitude because these models address the disability of a person ignoring the total person and his abilities. So it is widely believed that disability is the business of a few special people who run a few special institutions. ADD-I believes that disability is a development issue and therefore it is everybody's business.

The fundamental cause for the present situation of disabled people is not their disability but social attitudes and religious prejudices.

## Implementation

The first task of a development agency like ADD-I is to enable voluntary agencies to gain visibility to disability and to change attitudes towards disabled people. The task is also to enable the voluntary agencies to see disability not as a welfare issue but as a development issue.

Since disability has been construed as an issue that could be dealt with only by people with special skills, voluntary agencies naturally feel out of their depth and lack confidence to even consider work with disabled people. Enabling them to gain visibility to disability and to build their confidence are parts of the whole process of adding on disability as a development issue to the agenda of voluntary agencies. Training of staff, volunteers and the community in disability awareness, animation, programming, management, basic rehabilitation skills, skills training, networking, liaisoning with Government are all parts of the on-going process of establishing development work with disabled people in villages. The focus, therefore, is to train village people at all levels to work with disabled people or to become aware that disabled people have abilities. All they need is opportunity and support.

## Current Programme

At present ADD-I is working with three voluntary agencies in Andhra Pradesh, Karnataka and Tamilnadu. The result is that 41 self-help groups of disabled people have been established with a total membership of about 600. These disabled people come from 158 villages of seven taluks in four districts.

Six full time field workers support these 41 groups on a day to day basis. Out of the six, three are disabled.

Orthopaedically handicapped children are beginning to attend village schools, blind children are attending special schools. Attempts are being made to admit deaf children into special schools. 46 children have applied for scholarships.

103 disabled people belonging to five self-help groups have obtained financial assistance from the Government of Tamilnadu for income generating projects. About 200 disabled people have applied for similar assistance to the Government of Andhra Pradesh. More than 50 disabled people have obtained transport concessions.

Five self-help groups are striving to get land for collective farming from the Government. Old disabled people have applied for pension.

Disabled women are being facilitated to create a forum to deal with women's issues. Disabled women who are being wronged by their husbands are beginning to take action against them with the support of the self-help groups and the concerned voluntary agencies.

In addition the six workers are trained in Orientation and Mobility (O&M), Daily Living Skills (DLS) and Braille. As a result, blind people who have hitherto been shut in their homes, are beginning to move about on their own in their homes and in the village and do daily living things.

## Management Structure

Work with disabled people is part and parcel of the voluntary agency concerned. One of the office bearers of the voluntary agency is responsible and accountable for this work. All the staff of the agency support this work. The voluntary agency employs a full-time worker to do this work. This worker covers 35 villages. His/her task is primarily to animate groups of disabled people and support them in whatever they want to do to change their situation and to disseminate information.

## Manpower Development

One of the major problems in work with disabled people is the lack of trained manpower. So the key to the success of ADD-I's work with disabled people is to train village people.

ADD-I is in the fortunate position of having a policy to work through three existing voluntary agencies and is planning to work with many more in the future. Therefore, a large number of people are available for ADD-I to train to work with disabled people at different levels and in different areas.

## Networking

The governing principle of ADD-I's work is not to duplicate services. There are about 2000 institutions for disabled people both in the Government and voluntary sector. The thrust of ADD-I's work is to tap these resources to train village people preferably in the villages and also in the referral centres.

It is often stated that the voluntary sector does not even make use of the existing resources from the Government. Therefore, enabling disabled people and voluntary agencies to be aware of these resources and to liaise with Government to make use of these will be a major component of ADD-I's work.

## Capacity Building

Without management skills, men, money and material will be of little use. ADD-I's experience is that voluntary agencies do not recognise the need for management skills. Capacity building will therefore be a major support provided by ADD-I to the voluntary sector.

## Priority

The priorities for ADD-I are:

To enable voluntary agencies to work with disabled people in a developmental way,

To use the existing service deliverers to train village people as animators, skills development workers, basic rehabilitation workers, aid and appliances technicians in the village itself,

To enable self-help groups of disabled people to network among themselves and with other grass-root movements,

To enable voluntary agencies and disabled people to make optimum use of available resources from the Government of India and State Government schemes for rehabilitation, income generation, housing, transportation and so on,

To promote integrated education of disabled children in village schools, and

To campaign for the inclusion of disabled people in every Government programme and policy.

**Conclusion**

The fundamental difference between the rehabilitation and development models is that the services are not thrust upon disabled people by professionals and service deliverers but rehabilitation services are made available to disabled people if they ask for them. What the development model does is to put people first and disseminate information for them to decide what is best for them. This model gives dignity to disabled people and recognises them as people with disabilities who can do things for themselves with support. They decide instead of being passive recipients of a service about which they many not know much and where they are in a situation without choice. The development process enables them to have choice and to have the power to choose □

**B. Venkatesh.**

# Royal Commonwealth Society for the Blind

### The Organisation

The Royal Commonwealth Society of India for the Blind i.e. Sight Savers, as we are popularly known, is working in India since the last two decades. The Indian operations commenced on 1st January 1970, ie. 20 years after it was founded by Sir John Wilson in UK in 1950.

### Aims and Objectives

1. To prevent blindness and to promote the welfare, education and employment of the blind.
2. To foster collaboration between organisations for the blind for the prevention of blindness throughout the country and to promote activities in the benefit of such organisations.

### Area of Work

Although Sight Savers are now working in 50 Commonwealth Countries of the world, the bulk of their work is done in India, Bangladesh and Africa. This was the obvious decision, as the bulk of the blind population lives in these countries.

### Prevention of Blindness

Till recently, we were working in the places where it was possible for us to work. However, we have now realised that we should be working in areas where it is necessary for us to work, may be even in an impossible or difficult area. Having this in mind, we have classified the whole country into three different zones viz: fully served, underserved and unserved areas and the emphasis is to reduce our work in the fully served areas so that the underserved and unserved areas which are deprived of services get the benefit of our work.

We are primarily working in the field of prevention of blindness. 20 years ago when Sight Savers launched its "Eyes of India" Campaign, there were very few eye hospitals in the country. We mooted the idea of organising "Eye Camps". Eye camps were organised throughout the length and breadth of the country with the assistance of local hospitals, Government and District eye hospitals, charitable institutions, service organisations etc. The two major service organisations – Rotary and Lions – have included prevention of blindness as major part of their activities and are organising at least one eye camp each in a year. Sight Savers was instrumental in inducing the Government of India to initiate the preparation of National Programme for the Control of Blindness.

The Government of India which was hesitant initially to provide funds for organising eye camps has now allocated large funds for restoration of eyesight to one million people every year. The Government has also established mobile units attached to various district hospitals which are regularly used in Eye Camps.

### Mini Eye Hospitals

The scenario has now changed from "Eye Camps" to total "Eye Care" with the opening of new eye hospitals in various parts of the country. Sight Savers is now involved in providing total eye care services and has been instrumental in establishing 32 mini rural eye hospitals in the country. Some of these are established in backward places such as Telangana region of Andhra Pradesh, hilly terrains of Himachal Pradesh and in places like Purulia in West Bengal. The work of prevention is linked with the assistance of mobile eye units. About 96 vehicles are in use in various places.

### Catalyst Agency

It is estimated that there are about 17 million blind eyes in the country requiring surgery. Against this, the actual performance as per the Government of India statistics is hardly 1.1 million. Though there is a huge backlog between the demand for services and supply of the services, a charitable organisation like Sight Savers cannot be expected to shoulder the entire responsibility. We have set for ourselves a modest target of 1,50,000 surgeries every year. Sight Savers is a developing agency and our motto is to work as a catalyst agency to inspire the local communities, to work for themselves. Once the services are developed and the community is able to work for itself, we shift to different areas. We do not wish to work in any area or with any organisation on a permanent basis.

### Integrated Education

Apart from the work of "Prevention and Cure of Blindness" we are also involved in the activities of providing education, employment and rehabilitation for those with incurable Visual Handicap (VH). Realising that the integrated education is the need of the hour, we are now engaged in providing financial assistance towards development of integrated education of the VH where such children study side by side with sighted peers. Since the project of integrated education involves additional expenditure towards provisions of specialised teachers, books, etc. we are providing financial assistance so that a child needing formal education is not denied the same for lack of resources. 22 projects are now established throughout the country and we wish to expand it to at least 40 by the end of 1990. In addition to the finances available for integrated education we are also providing Braille kits to school going children.

**Community Based Rehabilitation**

There was a time when the visually handicapped flocked to cities for training and rehabilitation, as most of the rehabilitation centres are located in urban areas. This rehabilitation programme was not working satisfactorily for the following reasons:

a) Urban based training was not suitable to rural VH population, where they had to spend their life.
b) It was difficult for these trainees to re-adjust themselves to the rural atmosphere after spending some years in cities.
c) Urbanised training did not offer any job opportunity to VH persons who had to compete with other sighted unemployed.

Realising the above difficulties, Sight Savers launched its Community Based Rural Rehabilitation programme in a small way in 1982. Under this programme VH persons are not required to go to cities for any training but are rehabilitated in their own surroundings in the midst of their family members. This not only provided adequate training in the craft suited to them most but also created a sense of awareness and responsibility among family members and the community at large.

The following are the components of the services available to VH persons who have benefitted from this training programme:

a) Socio-economic rehabilitation,
b) Integrated education of school going children,
c) Availing government pension,
d) Free/concessional transport facility in state transport,
e) Restoration of sight wherever possible, and
f) Availing loan at concessional rates.

Sight Savers has so far launched 29 such projects at various locations throughout the country. Of these 16 projects have already been completed where the total number of VH beneficiaries was 4,348. An additional 13 programmes are still in operation where 3,594 VH persons are receiving various benefits. An important feature of this programme is that it has a snow-balling effect whereby other agencies have also shown interest and are now financing these projects. About 3,200 beneficiaries are enrolled in this programme funded by other agencies. It is hoped that the programme will be picked up by various other agencies, so that facilities are available wherever needed. We have plans to take this programme into the far off places of Himachal Pradesh, Jammu & Kashmir, Punjab, Haryana and Assam.

This work is developed with the help of a local implementing agency and the entire finance is provided by Sight Savers for each project for two years. 25 such projects will be in operation by December 1990 in different parts of the country □

**B.D. Thanawala**

# CARITAS – India

### History

CARITAS – India is the officially mandated organisation of the Catholic Bishops Conference of India (CBCI).

"Caritas" means Love and Caritas-India is an expression of the Christian concern for justice, peace and development.

Caritas – India was initiated by a resolution of the CBCI, passed at its general meeting held in 1960. It began working on 1st October 1962, as an organ of the CBCI, with headquarters in New Delhi. By January 1987 we had our network operating through 115 dioceses within the country and are affiliated to Caritas Internationalis (Rome) in a world wide chain of love linked together through 118 member countries in all continents around the globe.

### Objectives

According to the mandate given to it by the Catholic Bishops of India, Caritas-India exists to alleviate human suffering and misery in a spirit of Caritate Non-Ficta-Charity Unfeigned.

The objective, therefore, is to give concrete expression to Christian love in humanity so that all persons may individually and collectively grow into that fullness which God intended for each one of us. Hence our specific objective is: To educate people and make them conscious and concerned about social justice, co-operation and self-reliance, so that they may be prepared and equipped to work out for themselves and for others a future in keeping with their own human dignity and destiny. Caritas-India has seven regional offices in the following places, namely, Quilon, Nagpur, Madras, Imphal, Hyderabad, Calcutta, and Bangalore. The headquarters is located in New Delhi, has the following departments, namely, Shipping, Public Relations, Accounts, Emergency, Post-funding, Pre-funding, Animation – Promotion and Administration

### FUNCTIONS

### Human Development

The vision of Caritas – India is: "... to form a just society based on Gospel values of co-operation, participation, sharing, mutual concern and equality, with a clear option for the oppressed and the down trodden and belief in and respect for the instrinsic worth of the human person".

*Hence our thrust is a process that:*

- ☐ is educative in nature and promotes critical awareness of the people's actual situation, capabilities, rights and responsibilities.
- ☐ ensures people's organisation, people's power and people's action.
- ☐ is specifically oriented towards the under-privileged and oppressed section of the society.
- ☐ is relevant to the culture, needs and natural growth of the people and creates opportunities for groups as well as individuals to share with and understand each other.
- ☐ is economically viable and technically feasible.
- ☐ is designed for the formation and training of the local people to become masters of their own development.
- ☐ is planned to promote the development of women, children and other weaker sections.

### Animation & Promotion

The vision and thrust of Caritas is given life through our dynamic animation programmes. We believe that our facilitators and local leaders must be fully equipped to take up the task of achieving our vision.

For this purpose we have formulated regional fora and are also developing regional resource teams. Special training programmes, orientation courses, seminars and workshops are conducted throughout the year in different parts of the country.

*Our other activities are:*

- ☐ to disseminate our message through our campaign against hunger and disease.
- ☐ to develop educative materials including audio-visual aids.
- ☐ to undertake sale of books and also encourage and promote every other useful source for the above cause.

### Research

We also conduct research studies to evaluate our own programmes and projects. This helps us to review our methodology and approach, enhances our relevance and also helps to be progressively non-traditional in our work, when and where necessary.

### Bulletin

We also bring out a Bulletin (quarterly) which carries, the thought and record of the activities of our organisation and includes house information, current events in the field, important reports etc.

### Projects

Caritas has four categories of projects in line with its vision, named Development, Productive Projects, Welfare, and Relief and Rehabilitation.

DEVELOPMENT includes all projects that are related to the organisation of people who are motivated towards their own development and liberation by education. Promotion of people's organisation and education for awareness is our first priority.

PRODUCTIVE projects which aim at imparting technical skills and promoting the productive capacity of the people fall under this sector. One of the important components stressed in these projects is the participation of the people in various degrees towards bettering the quality of their lives. They are of various types such as institutional, non-institutional, production cum-training centres and vocational training institutes.

WELFARE projects include all the service oriented projects such as formal education, curative health and protective services like orphanages, foundling homes, centres/homes for the physically handicapped, the blind, the deaf and dumb, rehabilitation of the leprosy patients etc. In the rural areas these could include drinking water supply, mini health centres, nutrition programmes etc.

RELIEF & REHABILITATION projects take care of the victims of disasters like cyclones, floods, droughts, fires, communal riots and also Sri Lankan and other refugees.

We also have a shipping department for the import of gift supplies from different donor countries abroad, and their distribution within India.

**Legal Status**

*Registration* – Caritas-India is registered under the Societies Registration Act XX1 of 1860 (Punjab Amendment Act, 1957).

*Tax Exemption* – Donations to Caritas-India are eligible for tax relief under Section 88/80-G of the Income Tax Act, 1961, (43 of 1961) vide Govt. of India's Certificate No. JE-3/67 (105) of 12/2/70.

*Inter-Governmental Agreements* – Caritas-India is approved by the Government of India as a recipient agency under the Indo-UK, Indo-Swiss and Indo-German Agreements. We are also approved for exemption of customs duty for importing foodstuff, medicines, clothing and other consumable relief supplies from countries other than those covered by these bi-lateral agreements.

**AFFILIATIONS & COLLABORATION**

**International Affiliations**

*Caritas Internationalis*

As the Official Organisation of the CBCI, Caritas-India is a member of Caritas Internationalis (International Conference of Catholic Charities) and through this membership, has consultative status with ECOSOC, UNICEF, UNESCO, ILO and FAO of the United Nations.

*APHD*

Caritas-India is a member of the Asia Partnership for Human Development (APHD) consisting of counterpart partner agencies from the following 20 countries: (1) Australia, (2) Bangladesh, (3) Belgium, (4) Canada, (5) England, (6) France, (7) Hong Kong, (8) India, (9) Indonesia, (10) Ireland, (11) Japan, (12) Korea, (13) Malaysia, (14) Macao, (15) New Zealand, (16) Pakistan, (17) Philippines, (18) Sri Lanka, (19) Taiwan, (20) Thailand, and OHD (Office of Human Development) of the Federation of Asian Bishops Conferences.

**National Affiliations**

Our partner agencies in India are Catholic Relief services, Indo-German Social Service Society, Indian Social Institute, Voluntary Health Association of India and Catholic Hospitals Association, India. We are a member of the People's Action for Development (India) – PADI.

**Collaboration**

Caritas-India works in collaboration with: Australian Catholic Relief, Caritas Austria, Caritas Belgia, CEBEMO (Netherlands), Catholic Fund for Overseas Development (UK), Canadian Catholic Organisation for Development and Peace, Coady International (Canada), Le Cardinal Leger et Ses Oeuvres (Canada), Catholic Relief Services, Catholic Overseas Aid Committee (New Zealand), Committee Catholique Contre La Faim (France), COR UNUM (Vatican), Catholic Women's Movement (Austria) Entraide-et-Fraternite (Belgium), Caritas Germany, Dutch Bishops' Lenten Campaign, Caritas Italy, Caritas Luxembourg, Misereor (Germany), Cartias Netherlands, Caritas Norway, Caritas Denmark, Caritas Spain, Manos Unidas (Spain) Secours Catholique (France) Caritas Switzerland, Andheri Hilfe (Germany) Caritas Japan – including the 118 member countries which form the world wide family of Caritas Internationalis.

We always work within the frame work of National plans, needs and priorities in collaboration with the Central and State Governments at various levels.

Caritas-India believes in 'DEVELOPMENT' as a process of strengthening integral human growth, for the highest human fulfilment, by enabling people to restructure the societal systems to ensure the fullest freedom, justice and peace for every human person. Our main thrust and venture for achieving this vision is the animation of the powerless and voiceless – to enable them to challenge the oppressive and unjust forces and structures by breaking the culture of silence. We are hopeful for the dawn of a renaissance to establish the kingdom of God in this world.

Caritas-India understands the problems of poverty and under-development as being due to the existing man-made structural dictates. They are neither a static God-given reality nor the result of mere underdeveloped and under-utilised natural and human resources. On the contrary, they are the outcome of the unjust and exploitative socio-economic, political and cultural forces maintained by one privileged group over the other to further only its own material well being and prosperity. If poverty is man-made it can also be unmade by the people who are at the oppressed end.

Caritas-India firmly believes that the people have the capacity to uproot existing causes and restructure the systems and reshape their own destiny as well as their history – if they are appropriately facilitated to acquire critical consciousness through a process of education and awareness building. Caritas-India has un-wavering faith in man – to recreate and to establish a new and just social order through a process of education and organisation of the oppressed millions. This goes together with a basic and firm faith in the capacity of the people and respect for their growth and dignity.

This faith is rooted in our belief that God who is the author of history has already started this liberative work through men of good will and we insert ourselves in that great task □

**P. Christraj.**

# German Leprosy Relief Association Rehabilitation Fund

**Introduction**

The German Leprosy Relief Association is a voluntary organisation engaged in leprosy control work in India. It has 107 centres all over the country.

The German Leprosy Relief Association Rehabilitation Fund (GLRARF) is a registered voluntary organisation supported by German Leprosy Relief Association. It is engaged in the field of community based rehabilitation programmes for the past 15 years.

**The Problems of the Leprosy Patient**

Leprosy is a disease which is not merely a medical problem but also a social one. Therefore, it has to be handled on the basis of social dimensions also. What is meant by social problem here is the social stigma attached to the disease, society's attitudes towards the patients and how these influence the behaviour pattern of the individuals i.e. the patient as a member of the society.

Even though a person is declared medically cured of leprosy or certified as a negative or a non-infectious case, he is still neglected and separated from the normal functioning of the society at large. He finds it very difficult to assimilate himself with others and equal status is refused at all levels. He finds it very difficult to take up a job and enter into social contracts etc. It is apparent that apart from the social stigma, wrong notions and belief systems also hinder the process of socialisation and pose a big threat in achieving the goals or objectives of rehabilitation.

The social and economic conditions play a very important role in the displacement of the leprosy patients in addition to the disease. Economic dependency and poverty deepen their helplessness. In such a situation they tend to become beggers or criminals and anti-social gangs. So rehabilitation aims at total development of the person in all aspects.

**The Objectives of the Organisation**

1. To cater to the needs of the leprosy patients who are physically handicapped and at the same time mentally disturbed.
2. To speed up the process of the social assimilation of the patients and to slowly wipe out the social stigma attached to the disease.
3. To rehabilitate the handicapped persons in their natural home environment through different services such as helping to reactivate traditional occupations, starting fresh ones, placing for academic courses, job settlements etc. which suit their needs, capacities and aptitudes.

In order to achieve these goals of rehabilitation of the leprosy patient various social work methods, skills and techniques could be adopted depending upon the person, problem and work situation. The social work methods such as social case work, social group work and community organisation play a vital role in the rehabilitation of the leprosy patient.

The first and foremost aspect in social case work is to accept the person as he is. This would be helpful in the development of a good relationship between the case worker and the patient. Through this method an awareness about the disease can be created in the minds of the patient which would make him accept his disease as a curable one at all stages. He could also be made aware that he should take regular treatment. This process enables the leprosy patient to strengthen his ego. Supportive therapy can be given to help him to overcome his psychological trauma, to gain self-confidence and self-determination. He would thus be motivated to achieve the goals of rehabilitation.

Counselling and motivational techniques are effective tools in the hands of the social worker who deals with the problems of the patients. Counselling techniques, individual therapy, group therapy, collateral contacts, communication skills etc. would be of use in giving more insights into the various dimensions of the problem of the leprosy patients which is unique in nature when compared to other problems.

Social group work is also one of the methods which can be used effectively in the process of rehabilitation. The problems such as loneliness, withdrawal symptoms, rejection syndrome and inferiority complex can be brought under control through this method. An opportunity is provided to share problems with others. This would pave way for the acceptance of each other, participating and sharing with others. This would also create a trust and helping nature in the patient. Better socialisation of the patient can also be achieved through this method.

Once the patient reaches a stage where he is confident of himself, aware of his resources, skills and other potentialities, the community can be oriented to accept him. The community resources also can be mobilised for the rehabilitation of the patient.

**Activities of GLRARF**

Apart from the above methods there are some specific programmes of German Leprosy Relief Association Rehabilitation Fund which play an important role in the rehabilitation of the leprosy patients:

1. Providing interest free loans through German Leprosy Relief Association Rehabilitation Fund.
2. Providing loans through the Nationalised Banks.
3. Training the young boys in different job oriented courses suited to their needs and aptitudes.
4. Placing them for jobs.
5. Assistance for aged patients.
6. Children's Educational Aid programme.
7. Housing Scheme for the rehabilitated patients.
8. Other Welfare Activities:

    i) Providing Spectacles,
    ii) Providing Callipers, Wheel chairs & Tricycles,
    iii) Placing them for School, and
    iv) Counselling and Motivation.

**Loan Scheme**

The Loan scheme was mainly meant for the self-employment programmes. This is provided either through the German Leprosy Relief Association or through the Nationalised Banks. This has helped the patients for establishing businesses or trades. The patients have to repay their loan amount regularly and they are followed up regularly for this purpose as well as to solve their problems as and when they arise. Aged patients are supported through the Leprage Scheme.

Based on the success of the above programme we were able to get one more support from the Trickle-up-programme. Through this programme six families were supported in their domicillary rehabilitation efforts. 3,410 patients have been supported through this loan scheme.

**Training and Placements**

The young boys who have some educational qualifications and are physically handicapped were referred for the training to different training centres. Those who had completed their training were placed in different setups for jobs.

**Training Centre & Sheltered Workshop**

In order to train the leprosy affected and handicapped young boys and girls the following training centres have been established.

*A. GELRA Industries (Light Engineering Division)*

In this division the young leprosy affected boys as well as handicapped boys with minimum qualification of 8th standard are given training in the field of Turning, Welding, Spray Painting etc. The trainees are paid a stipend of Rs. 150/- for the first year and Rs. 200/- for the second year.

*B. Plastic Division*

In the Plastic Division the leprosy affected persons are given jobs as well as training in Injection moulding and Blow moulding.

*C. Tailoring Unit*

The Tailoring unit is exclusively established to give training in Tailoring and Embroidery for girls. This centre is supported by Icelandic Leprosy Children Aid, Iceland.

*Children's Education Programme*

The children of leprosy patients and children affected with leprosy are supported in their educational activities. So far 1,391 children have been supported in this regard. This programme gets donations from Save the Children Fund, Community Aid Sponsorship programme and also from local private sponsors and Indian Leprosy Foundations.

**Handicrafts by the Handicapped**

The products manufactured by our units and those made in different centres were marketed through this programme locally as well as through exports. There is a very good demand for our products.

**Housing Programme**

We had so far constructed 100 houses for the patients who were completely rehabilitated under this programme. Ten patients each were supported in different centres such as Madras, Kumbakonam, Pullambadi, Chettupattu, Chettipatty, Nailakkottai, Cochin, Palamner, Sherthalhey and Tenali. We had also given out Rs. 15,000/- to construct houses for each patient who has his own land. As per this scheme the patients have to repay the loan amount regularly, so that we could help more patients in future as well.

**Conclusion**

It is important to note that the professional social worker plays the role of a friend, philosopher and guide, he acts as a catalyst in the processs of socialisation of the patient with the community in his own environment. These days professonal social workers increasingly assist people of all social levels who are not economically independent in a wide variety of social situations. Unlike earlier charity practices professional social work enables the victims to find a remedy for their problems after analysing all possible alternatives. Whether the model is a traditional charity oriented social work or modern professional social work based on intellectual knowledge, skills and academic training, it is the fundamental personal qualities of dedication, patience, knowledge and kindness which must inspire the workers in their professional understandings □

**G. R. Srinivasan,**
Co-ordinating Rehabilitation Officer

# Brooke Bond India Ltd.

Brooke Bond India Limited requested 'SISTAS' to conduct a survery to assess the mode in which it could help the cause of the physically handicapped. This revealed that these are over a million amputees in the country and every year about 25,000 persons lose their limbs due to disease or injury. This number increases every year. As against this only about 10,000 artificial limbs are made in this country every year. This means that a larger number of amputees do not have a chance of being fitted with artificial limbs and have to depend on crutches or improvised crutches.

It was thus that Brooke Bond India Limited decided to be of help to the amputees by sponsoring an organisation which could fit artificial limbs and also help fit orthosis to polio victims. Further, the organisation would help in vocational training and rehabilitation of the physically handicapped. Thus the Anga Karunya Kendra was formed in September 1987, registered as a charitable society.

In October 1987, with the financial support of Brooke Bond India Limited a 'Jaipur Foot' camp was held at Infantry Road, Bangalore. A team of craftsmen from Bhagwan Mahavir Vikalang Sahayatha Samithi, Jaipur was invited to carry out fitment of Jaipur foot artificial limbs. The fitment of limbs, modest board and lodge for the amputees and their attendents was arranged free of cost. The response was overwhelming. In about 13 days 345 amputees were fitted with artificial limbs and 77 polio victims were fitted with calipers. A list of those who could not be fitted was prepared and they are now being fitted at the workshop of the Anga Karunya Kendra.

The 'Jaipur Foot Prothesis' has been further modified by using a fibre-glass shank instead of aluminium. This has helped to reduce the weight as well as thé cost of the limb. These limbs were evaluated for about 2 years and found satisfactory. In this Jaipur centre work is being carried out on HDPE shank.

At present the Anga Karunya Kendra has established a temporary workshop in the premises of Cheshire Home, Airport Road, Bangalore. It has employed a few craftsmen and has been able to fit about 100 limbs a year. Recently the Kendra conducted a camp at Kangaha, Kottayam, Kerala, with the help of MGDM Hospital and was able to fit 34 amputees with Jaipur type of prosthesis.

In addition to prosthesis, callipers were used for polio victims. Fitment of artificial limbs and callipers are done free of cost to the beneficiaries. The Kendra has been able to raise some funds by way of donations. Attempts are being made to collect donations which would help to fit larger number of amputees. It is also planned to have a permanent centre in the land allotted to the Kendra by the Government of Karnataka. When these buildings are ready, it is possible to fit about 1200 limbs a year in phase-I and about 2400 limbs a year in phase-II. In addition to the limbs, board and lodge for the amputees and their attendents would be free of cost. As soon as possible, Kendra has plans to commence work on the vocational and economic rehabilitation of the physically handicapped □

**Dr. V.K. Shetty.**

# Discussions

Chairperson: **Dr. G.G. Prabhu, Professor and Head, Department of Clinical Psychology, NIMHANS.**

The issue of the absence of networking amongst donor organisations in developing countries was discussed. The reason for this was felt to be either that no data base was available or that there was a reluctance to share the data.

With regard to operational aspects, the need to avoid duplication of efforts was repeatedly stressed, along with the need to share expertise, experiences and policies.

A suggestion that came up was to have an information data base to include aspects of fund mobilisation and funding guidelines of organisations.

Further to this, the importance of a documentation centre for voluntary agencies and funding organisations, since Government statistics tend to omit information about such organisations, was discussed. Such a documentation centre should not only collect information, but also collate information in terms of what is useful and what is not otherwise available, and disseminate the same. A combined newsletter of different funding organisations, recording successes and failures of activities could also be considered.

It was pointed out that the pooling of different kinds of resources, sharing of expertise and collaboration between funding organisations in the areas of service, training and research would be useful. Awareness building and changing attitudes towards disabled people in the able-bodied, and encouraging formation of self-help groups among the disabled are further areas to be considered.

Another suggestion was that the funding organisation network should interface with both Government and NGO activities. A system of accreditation of programmes with the Government could be developed, i.e. funding organistions could recommend programmes of voluntrary agencies to the Government, thereby recognising genuine efforts and avoiding dupliction of programmes.

Though it may be considered premature to talk about policy, it was pointed out that it was important for funding organisations to work towards common policy development and outlining of priority areas like prevention, training and so on, for future action. Further, funding organisations need to work towards legislation as well, e.g. removal of architectural barriers and minimum requirements for mobility in disabled people.

The need for promotion of self reliance and strengthening of management skills in voluntary organisations, and reduction of dependency on funding organisations was brought up.

It was pointed out that disability should be viewed as a developmental issue rather than as a segmental one, with emphasis on disabled people as participants in the process of rehabilitation instead of mere beneficiaries.

One suggestion for the Government was that a single window concept in programme implementation would be more appropriate instead of the existing implementation through the isolated efforts of four different ministries of education, health, welfare and labour.

The need to develop services in urban areas instead of emphasising rural areas alone was also brought up.

A note of caution was sounded in the point that a forum like this could not be ambitious enough to solve all the identified problems. It is more important instead to identify a limited number of objectives/priorities and then develop plans or mechanisms of action. Evaluation, it was suggested, was one such priority. While work has been going on for a number of years in the area of disability, there have been few attempts to answer the question of how effective this work has been. There had been too much of action and too little evaluation of the action. Possible areas for examination could be the actual needs of disabled people, the burden experienced by the families, and the benefits of programme interventions.

It was also pointed out that the much talked about recent policy statements to do with community based rehabilitation and 'integration' need to be critically evaluated to see if such approaches solve all the problems of disabled people, and what the successes and limitations of these concepts were. The word 'evaluation' tends to inspire fear, which was unnecessary. Organisations need to be open about their experiences so that others can learn from them.

Another issue that was brought up was the need to develop the necessary manpower to deal with the needs of the large numbers of disabled people. It was felt that the funding organisation network should examine this crucial issue more carefully.

The possibility of widening the scope of the forum to include other funding sources such as corporate bodies, banks and other financial institutions was discussed.

In connection with the issue of training the trainers and the development of technology, it was shared that the Nettur Technical Training Foundation (NTTF) was negotiating with the Japanese Government for a project to train disabled people in office automation, electronics and mechanical engineering.

In summing up, it was pointed out by the chairman that the major achievement had been the formation of a group of funding organisations. A number of issues had come up for discussion, not all of which could be addressed adequately in this forum. It was therefore important to focus on a few identified areas of specific concern to all □

# Future Plans of Action

Chairperson: **Dr. C.M. Francis, Director, St. Martha's Hospital.**

1. The delegates agreed that the networking forum was an extremely useful one and that it should be held once a year, to be conducted in rotation by the different organisations. It was decided that the months of February/ March would be most suitable for organising this meeting. The Christoffel Blinden Mission has tentatively agreed to host the next meeting in Madras or Trichy, with active support in organisation/co-ordination from Action-Aid.

2. It was decided that top priority should be given to building up an information base, with the mandates, policies, objectives, guidelines and activities of organisations supporting disability programmes, in order to share information and avoid duplication of efforts. It was agreed that Dr. R. Srinivasa Murthy, Professor and Head, Department of Psychiatry, NIMHANS, would work with ActionAid to develop a proforma for this purpose of gathering information. The possibility of widening the funding network could be addressed by circulating this proforma to all possible funding sources, including corporate houses, banks and other financial institutions. ActionAid is to collect, collate and disseminate this information.

3. It was agreed that expertise sharing between organisations was important and that the issue of what expertise is available for access to other organisations would be included in the proforma.

4. Manpower development in the area of disability was agreed upon as another priority area for consideration. It was decided that information would be shared about manpower projections in this field for the next few years and about how each organisation planned to fulfill the requirements.

5. The consensus was that it may be too early to discuss policy development. However, it was agreed that future meetings could address this issue, along with the issues of legislation, awareness building and research on disability programmes □

Glimpses of the proceedings